		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029975

Facility Name: WILSON CARE INC.

Address: 4544 N. HAZEL STREET (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 561-7241 **Fax #** (773) 728-2606

IDPA ID Number: 363379568001

Date of Initial License for Current Owners: 09/01/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) CARY C. BUXBAUM, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	198	Intermediate (ICF)	198	72,270	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	198	TOTALS	198	72,270	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	63,569	1,233		64,802	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	63,569	1,233		64,802	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.67%

D. How many bed-hold days during this year were paid by Public Aid?
2332 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/1/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/31/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified N/A and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	155,201	26,311	32,196	213,708		213,708	(19,793)	193,915			1
2	Food Purchase		243,744		243,744	(18,889)	224,855	(46)	224,809			2
3	Housekeeping	111,802	29,928		141,730		141,730	718	142,448			3
4	Laundry		13,430	7,405	20,835		20,835		20,835			4
5	Heat and Other Utilities			108,538	108,538		108,538	2,172	110,710			5
6	Maintenance	37,407		257,335	294,742		294,742	(76,143)	218,599			6
7	Other (specify):*							11,121	11,121			7
8	**TOTAL General Services**	304,410	313,413	405,474	1,023,297	(18,889)	1,004,408	(81,971)	922,437			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	926,900	11,543	92,992	1,031,435		1,031,435	(19,931)	1,011,504			10
10a	Therapy			17,580	17,580		17,580	(5,190)	12,390			10a
11	Activities	118,305	13,150		131,455		131,455		131,455			11
12	Social Services	231,965			231,965		231,965		231,965			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							6,011	6,011			15
16	**TOTAL Health Care and Programs**	1,277,170	24,693	114,172	1,416,035		1,416,035	(19,110)	1,396,925			16
	C. General Administration											
17	Administrative	90,623		307,217	397,840		397,840	(112,741)	285,099			17
18	Directors Fees											18
19	Professional Services			179,391	179,391	(17,863)	161,528	(94,963)	66,565			19
20	Dues, Fees, Subscriptions & Promotions			24,257	24,257		24,257	(6,537)	17,720			20
21	Clerical & General Office Expenses	76,500	20,556	62,451	159,507		159,507	27,620	187,127			21
22	Employee Benefits & Payroll Taxes			277,383	277,383	18,889	296,272	(6,767)	289,505			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,115	1,115		1,115	401	1,516			24
25	Other Admin. Staff Transportation			4,268	4,268		4,268	3,749	8,017			25
26	Insurance-Prop.Liab.Malpractice			60,616	60,616		60,616	1,281	61,897			26
27	Other (specify):*							30,344	30,344			27
28	**TOTAL General Administration**	167,123	20,556	916,698	1,104,377	1,026	1,105,403	(157,613)	947,790			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,748,703	358,662	1,436,344	3,543,709	(17,863)	3,525,846	(258,694)	3,267,152			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WILSON CARE INC. #0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			104,577	104,577		104,577	80,080	184,657			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			918	918		918	461,719	462,637			32
33	Real Estate Taxes			62,514	62,514	17,863	80,377	4,583	84,960			33
34	Rent-Facility & Grounds			614,280	614,280		614,280	(614,280)				34
35	Rent-Equipment & Vehicles			13,638	13,638		13,638	8,982	22,620			35
36	Other (specify):*							10,991	10,991			36
37	**TOTAL Ownership**			795,927	795,927	17,863	813,790	(47,925)	765,865			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,405	108,405		108,405		108,405			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			108,405	108,405		108,405		108,405			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,748,703	358,662	2,340,676	4,448,041		4,448,041	(306,619)	4,141,422			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,006)	30		9
10	Interest and Other Investment Income	(30,082)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(46)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(198)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,104)	21		24
25	Fund Raising, Advertising and Promotional	(2,726)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(21,324)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(64,292)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (136,778)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(169,841)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (169,841)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (306,619)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

WILSON CARE INC.

ID# 0029975

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty Income	$ (17)	10	1
2	Pay Phone Commissions	(490)	21	2
3	Non-allowable Legal Fees	(9,185)	19	3
4	Political Contributions - ICLTC	(3,927)	20	4
5	Cable TV	(1,430)	6	5
6	Capitalized Repairs & Maintenance	(42,476)	6	6
7	Employee Benefits	(6,767)	22	7
8				8
9				9
10				10
11				11
12				12
13				13
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91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(19,793)							(19,793)	1
2	Food Purchase	(46)											(46)	2
3	Housekeeping			718									718	3
4	Laundry													4
5	Heat and Other Utilities			867	1,305								2,172	5
6	Maintenance	(43,906)		643	(11,415)	(21,465)							(76,143)	6
7	Other (specify):*				708	10,413							11,121	7
8	**TOTAL General Services**	(43,952)		2,228	(9,402)	(30,845)							(81,971)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17)			(19,914)								(19,931)	10
10a	Therapy					(5,190)							(5,190)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,592	2,419							6,011	15
16	**TOTAL Health Care and Programs**	(17)			(16,322)	(2,771)							(19,110)	16
	C. General Administration													
17	Administrative			16,558	(61,529)	(54,582)		(13,188)					(112,741)	17
18	Directors Fees													18
19	Professional Services	(9,185)		(90,119)	(9,053)	13,297		97					(94,963)	19
20	Fees, Subscriptions & Promotions	(6,851)		84	171			59					(6,537)	20
21	Clerical & General Office Expenses	(31,918)		52,525	6,923			90					27,620	21
22	Employee Benefits & Payroll Taxes	(6,767)											(6,767)	22
23	Inservice Training & Education													23
24	Travel and Seminar			121	280								401	24
25	Other Admin. Staff Transportation			679	3,070								3,749	25
26	Insurance-Prop.Liab.Malpractice			448	650			183					1,281	26
27	Other (specify):*			9,583	8,401	11,863		497					30,344	27
28	**TOTAL General Administration**	(54,721)		(10,121)	(51,087)	(29,422)		(12,262)					(157,613)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(98,690)		(7,893)	(76,811)	(63,038)		(12,262)					(258,694)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WILSON CARE INC. # 0029975 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(8,006)	81,609	2,662	3,815								80,080	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(30,082)	487,066	1,181	3,554								461,719	32
33	Real Estate Taxes			1,620	2,963								4,583	33
34	Rent-Facility & Grounds		(614,280)										(614,280)	34
35	Rent-Equipment & Vehicles			2,755	4,766			1,461					8,982	35
36	Other (specify):*		10,991										10,991	36
37	**TOTAL Ownership**	(38,088)	(34,614)	8,218	15,098			1,461					(47,925)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(136,778)	(34,614)	325	(61,713)	(63,038)		(10,801)					(306,619)	45

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule Attached		See Schedule Attached		See Schedule Attached		
				Wilson Care LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 614,280	Wilson Care LLC	100.00%	$	$ (614,280)	1
2	V	32	Interest Income	159	Wilson Care LLC			(159)	2
3	V	32	Interest Expense		Wilson Care LLC		487,225	487,225	3
4	V	30	Depreciation		Wilson Care LLC		81,609	81,609	4
5	V	36	Amortization		Wilson Care LLC		10,991	10,991	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 614,439			$ 579,825	$ * (34,614)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 718	$ 718	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	867	867	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	643	643	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	16,558	16,558	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,881	1,881	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	84	84	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	52,525	52,525	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	121	121	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	679	679	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	448	448	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	9,583	9,583	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,662	2,662	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	1,181	1,181	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	1,620	1,620	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,755	2,755	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	92,000	PREFERRED BOOKKEEPING	100.00%		(92,000)	32
33	V	19	COMPUTER	4,752	PREFERRED BOOKKEEPING	100.00%	4,752		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 96,752			$ 97,077	$ * 325	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 1,305	$ 1,305	15
16	V	6	REPAIRS AND MAINT.	17,820	S.I.R. MANAGEMENT, INC.	100.00%	6,405	(11,415)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	708	708	17
18	V	10	NURSING	39,204	S.I.R. MANAGEMENT, INC.	100.00%	19,290	(19,914)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,592	3,592	19
20	V	17	ADMINISTRATIVE	69,492	S.I.R. MANAGEMENT, INC.	100.00%	7,963	(61,529)	20
21	V	19	PROFESSIONAL FEES	16,044	S.I.R. MANAGEMENT, INC.	100.00%	6,991	(9,053)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	171	171	22
23	V	21	CLERICAL & GENERAL	20,196	S.I.R. MANAGEMENT, INC.	100.00%	27,119	6,923	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	280	280	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	3,070	3,070	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	650	650	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	8,401	8,401	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	3,815	3,815	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,554	3,554	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	2,963	2,963	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,766	4,766	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 162,756			$ 101,043	$ * (61,713)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 20,196	S.I.R. MANAGEMENT, INC.	100.00%	$ 5,639	$ (14,557)	15
16	V	7	EMP. BEN.-DIETARY	1,061	S.I.R. MANAGEMENT, INC.	100.00%	1,061	1,061	16
17	V	17	ADMIN./LEGAL SALARIES	120,000	S.I.R. MANAGEMENT, INC.	100.00%	65,418	(54,582)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	13,297	13,297	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	11,863	11,863	19
20	V								20
21	V								21
22	V	10A	SPECIAL REHAB	17,580	S.I.R. MANAGEMENT, INC.	100.00%	12,390	(5,190)	22
23	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	2,419	2,419	23
24	V								24
25	V								25
26	V	6	REPAIRS AND MAINT.	62,604	S.I.R. MANAGEMENT, INC.	100.00%	41,139	(21,465)	26
27	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	8,032	8,032	27
28	V								28
29	V								29
30	V	1	DIETICIAN SALARIES	12,000	S.I.R. MANAGEMENT, INC.	100.00%	6,764	(5,236)	30
31	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,320	1,320	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 232,380			$ 169,342	$ * (63,038)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 46,353	$ 46,353	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	46,353	CCS EMPLOYEE BENEFIT GROUP	100.00%		(46,353)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 46,353			$ 46,353	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 97	$ 97	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	59	59	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	90	90	17
18	V	26	INSURANCE		ECM OWNERS COUNCIL	100.00%	183	183	18
19	V	35	VEHICLE RENTAL		ECM OWNERS COUNCIL	100.00%	1,461	1,461	19
20	V	17	MANAGEMENT FEES	21,600	ECM OWNERS COUNCIL	100.00%		(21,600)	20
21	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	8,412	8,412	21
22	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	497	497	22
23	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%			23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,600			$ 10,799	$ * (10,801)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Shareholder	Administrative	11.11%	See Attached	4.12	9.15%	All. Salary	$ 17,185	17-7	1
2	Noah Wolf	Shareholder	Administrative	5.56%	See Attached	3	7.14%	Mgmt. Fees	48,000	17-3	2
3	Nenita Guzman	Relative	Dietary	0	See Attached	5.15	10.30%	All. Salary	5,639	1-7	3
4	Arturo Rominiquit	Relative	Clerical	0	See Attached	4.26	10.65%	All. Salary	2,412	21-7	4
5	Eric Rothner	Shareholder	Administrative	20.00%	See Attached	.65	0.90%	All. Salary	1,585	17-7	5
6	Howard Geller	Shareholder	Administrative	4.44%	See Attached	2	3.33%	Mgmt. Fees	48,000	17-3	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 122,821		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	863,792	11	$ 6,745	$	92,000	$ 718	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	863,792	11	8,137		92,000	867	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	863,792	11	6,035		92,000	643	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	863,792	11	155,464	155,464	92,000	16,558	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	863,792	11	17,663		92,000	1,881	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	863,792	11	788		92,000	84	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	863,792	11	493,157	432,172	92,000	52,525	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	863,792	11	1,135		92,000	121	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	863,792	11	6,379		92,000	679	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	863,792	11	4,205		92,000	448	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	863,792	11	89,973		92,000	9,583	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	863,792	11	24,993		92,000	2,662	12
13	32	INTEREST	BOOK./ACCNT.INCOME	863,792	11	11,085		92,000	1,181	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	863,792	11	15,206		92,000	1,620	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	863,792	11	25,868		92,000	2,755	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						4,752	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 866,833	$ 587,636		$ 97,077	25

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	629,428	10	$ 12,680	$	64,802	$ 1,305	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	629,428	10	62,210	44,382	64,802	6,405	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	629,428	10	6,878		64,802	708	3
4	10	NURSING	PATIENT DAYS	629,428	10	187,368	187,368	64,802	19,290	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	629,428	10	34,893		64,802	3,592	5
6	17	ADMINISTRATIVE	PATIENT DAYS	629,428	10	77,349	77,349	64,802	7,963	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	629,428	10	67,899		64,802	6,991	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	629,428	10	1,658		64,802	171	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	629,428	10	263,413	213,455	64,802	27,119	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	629,428	10	2,720		64,802	280	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	629,428	10	29,820		64,802	3,070	11
12	26	INSURANCE	PATIENT DAYS	629,428	10	6,309		64,802	650	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	629,428	10	81,605		64,802	8,401	13
14	30	DEPRECIATION	PATIENT DAYS	629,428	10	37,059		64,802	3,815	14
15	32	INTEREST	PATIENT DAYS	629,428	10	34,524		64,802	3,554	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	629,428	10	28,776		64,802	2,963	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	629,428	10	46,289		64,802	4,766	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 981,450	$ 522,555		$ 101,043	25

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	629,428	10	$ 54,767	$ 54,767	64,802	$ 5,639	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	629,428	10	10,305		64,802	1,061	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	629,428	10	635,411	635,411	64,802	65,418	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	629,428	10	129,159		64,802	13,297	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	629,428	10	$ 115,229	$	64,802	$ 11,863	5
6										6
7										7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	58,457	58,457	17,580	12,390	8
9	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	$ 11,413	$	17,580	$ 2,419	9
10										10
11										11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	221,184	10	145,348	145,348	62,604	41,139	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	221,184	10	$ 28,377	$	62,604	$ 8,032	13
14										14
15										15
16	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	70,679	70,679	12,000	6,764	16
17	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	13,799		12,000	1,320	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,272,944	$ 964,662		$ 169,342	25

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 46,353	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 46,353	25

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60646
Phone Number: (847) 676-2026
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	96,000	9	$ 430	$	21,600	$ 97	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	96,000	9	264		21,600	59	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	96,000	9	400		21,600	90	3
4	26	INSURANCE	ECMOC MGMNT FEE INC.	96,000	9	813		21,600	183	4
5	35	VEHICLE RENTAL	ECMOC MGMNT FEE INC.	96,000	9	6,493		21,600	1,461	5
6	17	MANAGEMENT FEES	ECMOC MGMNT FEE INC.	96,000	9			21,600		6
7	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	39	9	79,839	79,839	4	8,412	7
8	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	39	9	4,713		4	497	8
9	17	ADMIN. SALARY	DIRECT ALLOCATION		6	(539)				9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 92,413	$ 79,839		$ 10,799	25

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Nomura		X	Mortgage	$48,561	3/1/95	$ 5,817,265	$ 5,483,584	2/21/08	8.69%	$ 488,143	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$48,561		$ 5,817,265	$ 5,483,584			$ 488,143	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(25,506)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (25,506)	14
15	TOTALS (line 9+line14)						$ 5,817,265	$ 5,483,584			$ 462,637	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income		X				$	$			$ (30,082)	1
2	Interest Income - Bldg	X									(159)	2
3	Allocation-Preferred Bkpg.	X									1,181	3
4	Allocation-SIR Management	X									3,554	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (25,506)	21

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		$ 79,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 74,597	2
3. Under or (over) accrual (line 2 minus line 1).		$ (4,903)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 72,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 17,863	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 84,960	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	91,962	8
	1997	76,201	9
	1998	77,554	10
	1999	77,033	11
	2000	70,014	12

Accrual: $70,014 X 1.03 = $72,114 (rounded to 72,000)

Allocation Preferred Bookkeeping $1620

Allocation SIR Management $2963

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WILSON CARE INC. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0029975

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda (847) 236-1111

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-220-009-0000	Long Term Care Property	$ 70,014.00	$ 70,014.00
2.	See Attached	Home Office	$ 64,023.09	$ 4,713.07
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 134,037.09	$ 74,727.07

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,020 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1985	$ 13,300	1
2					2
3	TOTALS			$ 13,300	3

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1985	65,366		20	3,441	3,441	55,610	9
10	Various			1986	161,365		20	8,493	8,493	132,131	10
11	Various			1987	49,380		20	2,598	2,598	38,185	11
12	Various			1989	49,210		20	2,461	(2,461)	30,906	12
13	Various			1990	105,470		20	5,274	5,274	58,462	13
14	Various			1991	29,903		20	1,494	1,494	15,787	14
15	Various			1992	69,669		20	3,484	3,484	33,293	15
16	Various			1993	61,688		20	3,087	3,087	26,194	16
17	Various			1994	55,691		20	2,917	2,917	21,681	17
18	Various			1995	87,144		20	4,360	4,360	28,339	18
19	Various			1996	303,393		20	15,172	15,172	82,495	19
20	Various			1997	145,411		20	7,492	7,492	33,712	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		1,625,627	84,778		47,379	(37,399)	690,321	68
69	Financial Statement Depreciation			104,578			(104,578)		69
70	TOTAL (lines 4 thru 69)		$ 2,809,317	$ 189,356		$ 107,652	$ (86,626)	$ 1,247,116	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,809,317	$ 189,356		$ 107,652	$ (81,704)	$ 1,247,116	1
2	ELEVATOR WORK	1998	6,635		20	332	332	1,273	2
3	SECURITY SYSTEM	1998	5,956		20	298	298	1,118	3
4	NURSES STATION	1998	11,997		20	600	600	2,050	4
5	CARPET & MINI BLINDS	1998	875		20	44	44	158	5
6	WALLPAPER	1998	807		20	40	40	140	6
7	ELEVATOR PANELS	1998	2,145		20	107	107	375	7
8	ELEVATOR TEES	1998	2,427		20	121	121	413	8
9	VCT/NURSES STATION	1998	2,684		20	134	134	447	9
10	VCT/RECEPTION	1998	1,433		20	72	72	228	10
11	TUCKPOINTING	1999	5,300		20	265	265	773	11
12	HVAC WORK	1999	27,900		20	1,395	1,395	3,836	12
13	S.I.R. REMODELING	1999	11,079		20	554	554	1,247	13
14	ROOFING	1999	975		20	49	49	147	14
15	BLINDS	1999	1,849		20	92	92	261	15
16	ELECTRICAL	1999			20				16
17	CUBICLE CURTAINS	1999	2,453		20	123	123	328	17
18	DOORS	1999			20				18
19	HEAT COOL SLEVE	1999	1,650		20	83	83	173	19
20	PIPE REPLACEMENT	1999	3,618		20	181	181	422	20
21	2 NEW CAR GATES	1999	5,780		20	289	289	674	21
22	FLOORING	1999	1,234		20	62	62	134	22
23	ELECTRICAL	1999	2,719		20	191	191	509	23
24	PAINTING	2000	15,000		20	750	750	1,188	24
25	FLOOR & WALL TILE	2000	13,197		20	660	660	935	25
26	KITCHEN TILES	2000	13,147		20	657	657	876	26
27	PUMP	2000	5,677		20	284	284	355	27
28	TILE WORK	2000	62,060		20	3,103	3,103	3,879	28
29	DINING ROOM	2000	24,287		20	1,214	1,214	1,518	29
30	TILE WORK	2000	2,013		20	101	101	118	30
31	PAINTING	2000	15,000		20	750	750	1,125	31
32	PAINTING	2000	30,000		20	1,500	1,500	2,125	32
33	PAINTING	2000	30,000		20	1,500	1,500	1,875	33
34	TOTAL (lines 1 thru 33)		$ 3,119,214	$ 189,356		$ 123,203	$ (66,153)	$ 1,275,816	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,119,214	$ 189,356		$ 123,203	$ (66,153)	$ 1,275,816	1
2	FIRE DOORS	2000	35,264		20	1,763	1,763	2,938	2
3	ROOM DIVIDER	2000	20,600		20	1,030	1,030	1,202	3
4	WINDOW TREATMENT	2000	1,046		20	52	52	95	4
5	WINDOW TREATMENT	2000	1,044		20	52	52	78	5
6	KITCHEN REMODEL	2000			20				6
7	ELECTRIC WORK	2000	2,585		20	129	129	194	7
8	STOWELL REMODEL	2000	1,798		20	90	90	128	8
9	PAINTING	2000	5,900		20	295	295	320	9
10	PAINTING	2000	24,447		20	1,222	1,222	1,324	10
11	TILE WORK	2000	8,474		20	424	424	459	11
12	KITCHEN REMODEL	2000	6,623		20	326	326	435	12
13	RADIATOR	2000	1,055		20	53	53	106	13
14	MIXING VALVE	2000	1,138		20	57	57	114	14
15	CONCRETE	2000	1,500		20	75	75	131	15
16	BORDERS	2000	542		20	27	27	32	16
17	CARPET	2000	633		20	32	32	35	17
18	INTERIOR SUPPLY	2000	1,582		20	79	79	112	18
19	DINING A/C	2000	1,239		20	25	25	40	19
20	CONCRETE	2000	1,000		20	50	50	63	20
21	WATER HEATER	2000	5,120		20	512	512	853	21
22	LIGHTS FIXTURE	2000	7,807		20	781	781	976	22
23	TUCKPOINTING	2000	2,440		20	122	122	122	23
24	FLOORING	2001	24,235		20	1,212	1,212	1,212	24
25	WINDOW TREATMENT	2001	6,946		20	347	347	347	25
26	DOORS	2001	6,905		20	345	345	345	26
27	ELEVATOR WORK	2001	5,690		20	166	166	166	27
28	SECURITY SYSTEM	2001	8,340		20	209	209	209	28
29	HVAC SYSTEM	2001	5,175		20	108	108	108	29
30	HVAC WORK	2001	11,902		20	50	50	50	30
31	PAINT	2001	718		20	36	36	36	31
32	BOOSTER HEATER	2001	1,523		20	76	76	76	32
33	FIRE DOOR	2001	1,221		20	61	61	61	33
34	TOTAL (lines 1 thru 33)		$ 3,323,706	$ 189,356		$ 133,009	$ (56,347)	$ 1,288,183	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,323,706	$ 189,356		$ 133,009	$ (56,347)	$ 1,288,183	1
2	DOORS	2001	1,851		20	93	93	93	2
3	BLINDS	2001	1,187		20	59	59	59	3
4	AQUASTAT	2001	1,064		20	53	53	53	4
5	FIRE DOOR	2001	1,227		20	61	61	61	5
6	BLINDS	2001	1,194		20	60	60	60	6
7	FIRE DOOR	2001	1,495		20	75	75	75	7
8	BLINDS	2001	1,194		20	60	60	60	8
9	CAMERA	2001	951		20	48	48	48	9
10	WINDOW TREATMENT	2001	6,946		20	347	347	347	10
11	BATHTUB LINER	2001	3,186		20	159	159	159	11
12	REFINISH TUB	2001	2,610		20	131	131	131	12
13	HOT WATER HEATER	2001	1,789		20	89	89	89	13
14	WATER HEATER	2001	1,276		20	64	64	64	14
15	LIGHTING	2001	2,060		20	103	103	103	15
16	PLUMBING REPAIR	2001	1,948		20	97	97	97	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,353,684	$ 189,356		$ 134,508	$ (54,848)	$ 1,289,682	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,353,684	$ 189,356		$ 134,508	$ (54,848)	$ 1,289,682	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,353,684	$ 189,356		$ 134,508	$ (54,848)	$ 1,289,682	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,353,684	$ 189,356		$ 134,508	$ (54,848)	$ 1,289,682	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,353,684	$ 189,356		$ 134,508	$ (54,848)	$ 1,289,682	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,353,684	$ 189,356		$ 134,508	$ (54,848)	$ 1,289,682	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,353,684	$ 189,356		$ 134,508	$ (54,848)	$ 1,289,682	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,353,684	$ 189,356		$ 134,508	$ (54,848)	$ 1,289,682	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,353,684	$ 189,356		$ 134,508	$ (54,848)	$ 1,289,682	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,353,684	$ 189,356		$ 134,508	$ (54,848)	$ 1,289,682	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,353,684	$ 189,356		$ 134,508	$ (54,848)	$ 1,289,682	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1985		$ 1,539,800	$ 81,609	35	$ 43,994	$ (37,615)	$ 668,196	4
5			1993		15,039	478	35	430	(48)	3,652	5
6			1993		27,510	873	35	786	(87)	6,681	6
7											7
8											8
	Improvement Type**										
9	Allocation from Preferred Bookkeeping			1997	18,782	420	20	939	519	4,516	9
10	Allocation from Preferred Bookkeeping			1999	149	29	20	7	(22)	19	10
11	Allocation from Preferred Bookkeeping			2000	942		20	47	47	67	11
12											12
13	Allocation from SIR Prop-Preferred Bookkeeping			1999	1,906	191	20	95	(96)	238	13
14	Allocation from SIR Prop-Preferred Bookkeeping			1998	911	91	20	46	(45)	159	14
15	Allocation from SIR Prop-Preferred Bookkeeping			1997	57	6	20	3	(3)	16	15
16	Allocation from SIR Prop-Preferred Bookkeeping			1994	143	4	20	7	3	54	16
17	Allocation from SIR Prop-Preferred Bookkeeping			1993	244	7	20	12	5	104	17
18											18
19	Allocation from SIR Management			1993	11,815	329	20	596	267	5,253	19
20	Allocation from SIR Management			1994	37		20	4	4	27	20
21	Allocation from SIR Management			1995	270		20	13	13	87	21
22	Allocation from SIR Management			1999	1,283	61	20	64	3	142	22
23	Allocation from SIR Management			2000	775	135	20	39	(96)	65	23
24											24
25	Allocation from SIR Prop-SIR Management			1999	3,486	349	20	174	(175)	436	25
26	Allocation from SIR Prop-SIR Management			1998	1,666	167	20	83	(84)	292	26
27	Allocation from SIR Prop-SIR Management			1997	104	10	20	5	(5)	29	27
28	Allocation from SIR Prop-SIR Management			1994	262	7	20	13	6	98	28
29	Allocation from SIR Prop-SIR Management			1993	446	12	20	22	10	190	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,625,627	$ 84,778		$ 47,379	$ (37,399)	$ 690,321	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 523,300	$ 3,178	$ 48,343	$ 45,165	10	$ 366,072	71
72	Current Year Purchases	27,733	132	1,809	1,677	10	1,809	72
73	Fully Depreciated Assets	324,328				10	294,328	73
74								74
75	TOTALS	$ 875,361	$ 3,310	$ 50,152	$ 46,842		$ 662,209	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,242,345	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 192,666	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 184,660	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (8,006)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,951,891	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 15,759 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility Van	1999 Dodge	$ 450	$ 5,400	17
18	Allocation from ECM Owners Council			1,461	18
19					19
20					20
21	TOTAL		$ 450	$ 6,861	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs		$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 15,986	$ 21,160	1
2	Cash-Patient Deposits	25,742	25,742	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,189,256	1,189,256	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,915	9,915	6
7	Other Prepaid Expenses	1,413	1,413	7
8	Accounts Receivable (owners or related parties)	85,000	85,000	8
9	Other(specify): See supplemental schedule	26,109	26,109	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,353,421	$ 1,358,595	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		25,200	13
14	Buildings, at Historical Cost		1,539,800	14
15	Leasehold Improvements, at Historical Cost	1,145,740	1,145,740	15
16	Equipment, at Historical Cost	1,044,010	1,105,501	16
17	Accumulated Depreciation (book methods)	(1,291,302)	(2,675,482)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	4,125	71,441	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 902,573	$ 1,212,200	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,255,994	$ 2,570,795	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 100,703	$ 100,702	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,815	27,815	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	144,817	144,817	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,066	9,066	31
32	Accrued Real Estate Taxes(Sch.IX-B)	72,000	72,000	32
33	Accrued Interest Payable		27,797	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	21,450	21,450	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	45,031	45,031	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 420,882	$ 448,678	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,483,584	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,483,584	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 420,882	$ 5,932,262	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,835,112	$ (3,361,467)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,255,994	$ 2,570,795	48

*(See instructions.)

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,650,472	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,650,472	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,408,640	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(1,224,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 184,640	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,835,112	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,824,992	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,824,992	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	30,082	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30,082	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	1,607	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,607	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,856,681	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,023,297	31
32	Health Care	1,416,035	32
33	General Administration	1,104,377	33
	B. Capital Expense		
34	Ownership	795,927	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	108,405	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,448,041	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,408,640	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,408,640	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,846	2,094	$ 65,892	$ 31.47	1
2	Assistant Director of Nursing	1,789	2,086	49,084	23.53	2
3	Registered Nurses	604	604	11,185	18.52	3
4	Licensed Practical Nurses	12,806	13,550	248,891	18.37	4
5	Nurse Aides & Orderlies	55,274	58,385	519,633	8.90	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,732	3,110	46,004	14.79	9
10	Activity Assistants	7,653	8,349	72,301	8.66	10
11	Social Service Workers	23,336	24,526	231,965	9.46	11
12	Dietician					12
13	Food Service Supervisor	1,877	2,087	31,587	15.14	13
14	Head Cook	4,289	4,536	34,116	7.52	14
15	Cook Helpers/Assistants	13,278	13,926	89,498	6.43	15
16	Dishwashers					16
17	Maintenance Workers	3,282	3,990	37,407	9.38	17
18	Housekeepers	16,476	17,265	111,802	6.48	18
19	Laundry					19
20	Administrator	1,917	2,086	90,623	43.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,676	7,229	76,500	10.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,812	3,050	32,215	10.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	156,647	166,873	$ 1,748,703 *	$ 10.48	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 12,000	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant	96	4,032	10-03	37
38	Nurse Consultant	SIR Mgmt	39,204	10-03	38
39	Pharmacist Consultant	30	1,440	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Director of Food Service	Monthly	20,196	01-03	47
48	Special Rehab.	SIR Mgmt	17,580	10a-03	48
49	TOTAL (lines 35 - 48)	126	$ 98,052		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	1,810	48,316	10-03	52
53	TOTAL (lines 50 - 52)	1,810	$ 48,316		53

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Charlene Hill-Jeon	Adminstrator	0	$ 90,623
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,623

B. Administrative - Other

Description	Amount
Management Fees - See Attached	$ 237,725
Management Service Fees - See Attached	69,492
TOTAL (agree to Schedule V, line 17, col. 3)	$ 307,217
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SIR Management	Dir of Reg Services	$ 16,044
Preferred Bookkeeping	Bookkeeping	59,400
Preferred Bookkeeping	Accounting	32,600
Preferred Bookkeeping	Computer	4,752
Frost, Ruttenberg & Rothblatt	Accounting	12,703
Personnel Planners	Unemployment Consult	1,400
ICS Solutions	Computer	1,104
Mid America Programming	Computer	1,320
Rieff Schramm & Kanter	Legal-R/E Tax Appeal	17,863
Schwartz & Freeman	Legal	13,440
Michael Best & Friedrich	Legal	9,579
Stone, McGuire & Benjamin	Legal	9,185
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 179,390

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,846
Unemployment Compensation Insurance	11,034
FICA Taxes	131,649
Employee Health Insurance	29,976
Employee Meals	18,889
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	12,468
Union Health & Welfare	57,671
Chicago Head Tax	3,972
TOTAL (agree to Schedule V, line 22, col.8)	$ 289,505

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,110
Health Care Worker Background Check	373
(Indicate # of checks performed 53)	
Dues & Subscriptions	4,765
Licenses & Fees	3,158
Allocation-Preferred Bookkeeping	84
Allocation-SIR Management	171
Allocation-ECM Owner's Council	59
Less: Public Relations Expense	
Non-allowable advertising	
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,720

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,115
Allocation-Preferred Bookkeeping	121
Allocation-SIR Management	280
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,516

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Painting & Decorating	06/01/97	$ 14,183		$ 4,727	$ 4,727	$ 2,363	$	$	$	$	$	$
2													
3													
4													
5													
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20	TOTALS		$ 14,183		$ 4,727	$ 4,727	$ 2,363	$	$	$	$	$	$

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $8692**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **No** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **108,405**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **18,889** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% In 1**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees